

# Questions Asked During Live Webinar Broadcast on 4/03/2020



## *The Impact of Disaster on Recovery: The Perfect Storm*

Presenter: Timothy Legg, PhD, PsyD, PMHNP-BC,  
MAC

### **Do you believe Coronavirus will spike PTSD?**

A: It can; again it depends on those pre/peri/post traumatic factors.

### **How did these studies differentiate an increase in substance 'use' versus an increase in substance 'abuse'?**

A: That was still another problem with several of these studies. Their operational definitions of variables under consideration were not the same as each other, which makes it even more difficult to compare studies.

### **What are some ideas or tools used to engage youth who do not want to be engaged?**

A: Please see the resources from the slides

### **How do you handle a situation that your client's mother is an addict, even though she claims she is in recovery from alcohol?**

A: I am assuming that this question refers to someone who is “actively” using to the point of impairment. In that case, it would depend on several factors, including the age of the client, other supports available in the home, etc. Of particular importance is if the client is a minor, if I have reason to suspect the child is being neglected or experience other deprivation due to the mother’s substance intoxication, applicable state laws governing mandatory reporting come into play.

### **What are some specific ideas/suggestions for increased treatment that is being done telephonically? We are conducting all treatment over the phone and if we have someone who is using substances again what are some real examples we can have them do to assist in helping?**

A: One of the things I do advocate is increasing your frequency of contact. This is something I have been doing in my own practice. Clients are appreciative of the additional support. I would also encourage the client (if they are AA/NA, SMART recovery, etc., involved) to consider virtual meetings. This is also a great time for mindfulness and journaling. I have a few clients who were very resistant to journaling who have taken it up due to excessive “free” time.

### **Are there any client and family/SO centered recovery strategies/approaches/interventions/techniques you might consider for assisting and supporting sheltered in place families with multiple members experiencing co-occurring disorders and where some members may be experiencing treatment non-compliance and or actively using AOD?**

A: This depends on family dynamics and individual client perceptions of support from other family members. Assuming that there is good “chemistry” in the family unit, you may be able to suggest such interventions as a daily meeting where everyone comes together just as they would in a support group and talk about how they are feeling (of course with the caveat that they only share what they feel comfortable sharing with one another). If you have a family with a lot of support, this could be very empowering for the group, and can also be very powerful for the person struggling to maintain abstinence.

Now, if you have a family with multiple individuals struggling with substance use disorder who are abstinence discordant (i.e., one person may be using, while two others are abstaining, etc.), and with very challenging family dynamics, this will be more of a challenge. In these cases, while definitely “invite” person who is “using” by to move towards abstinence, the primary focus would be on those individuals who are struggling to maintain their

absence. More frequent contact can be crucial. Additionally, encouraging them to consider AA or NA, or other group meetings online could help them to feel more connected and supported.

### **How do we deal appropriately with other professional staff whom are not practicing best practices when it comes to Covid-19 prevention in the workplace?**

A: I believe in using an educational approach. It could very well be that they don't fully know what to do, or how to do it. In these cases, education works best. However, if I see that somebody is simply practicing with reckless abandon, I take it right back to ethics. Our first duty to our clients is to do no harm. While nobody wants to be the proverbial "tattletale" there are times when we need to involve our supervisors in these situations.

### **What is some advice you would have for an undergraduate student working in the field?**

A: Persist! There are so many people that need our assistance right now, that we cannot afford to lose a single person interested in pursuing this very important career. Also, listen to that little voice inside of you that tells you what you need to do. I recall one particular professor in my undergraduate education who discouraged me from wanting to work with individuals who struggle with substance use disorders because she felt that I was too prone to being "manipulated." I am so glad that I never listened to her!

### **Do you have any advice for disaster outreach workers/crisis counselors for ways they can support people that aren't clinical?**

A: Yes, be patient! There are so many people right now trying to do what they could to meet the needs of so many. Not all of them are clinical, but they have hearts that are in the right place—and that is precisely what is needed when working in times of disaster! You can work with them to acquire skills and abilities. Take the time to teach them something new, be patient with them, be a model and mentor, and encourage them to ask questions.

### **I see the correlation between increase alcohol use. Has there been an increase in other drug use as well, i.e. methamphetamines, opiates?**

A: Several studies have noticed increases in methamphetamines, and opioids as well. Again, some of the findings contradict one another.

### **So is Covid 19 a natural or man-made disaster?**

A: This would meet the criteria for a man-made disaster. While the virus responsible for COVID-19 comes from nature, humans have spread it (and continue to spread it) from one to the other through failing to maintain social distancing, poor hygienic practices, etc.

### **How about individuals who are left in the illicit market that need super low threshold access to regulated markets, ie methadone, prescribing, to replace the illicit market, or we will be unable to implement social distancing across the drug using culture, and render our response completely ineffective to contain covid-19? Shouldn't our goal to reach 80-90% replacement of that system to promote necessary social distancing requirements to prevent the spread of COVID-19 across the entirety of the drug using community? Would it not overwhelm our health system if we were not succesful in replacing the illicit market in a very short matter of time?**

A: This is a great question! Independent of the current COVID-19 pandemic, many individuals who would benefit from medication-assisted treatment (MAT) (i.e., methadone and buprenorphine) are unable to access it due to a variety of factors including but not limited to access to prescribers, transportation issues, financial issues, etc. I think we need to do a much better job expanding our capacity to meet the needs of those who would benefit from MAT. MAT programs are still be functioning right now. Clinics should be requiring program participants to maintain social distancing, hand hygiene, etc. Prescribers also need to ask themselves if it's appropriate to alter existing numbers of take-home doses based on their assessment of the client. This is also important time for outreach and that individuals experiencing financial difficulty, and are unable to afford illicit opioids may experience uncomfortable withdrawal symptoms.

Unfortunately, there are still many providers who do not endorse harm reduction, and although eligible for the waiver program, do not pursue it. I have also spoken with other providers who seem to feel that prescribing methadone and buprenorphine is “more trouble than it is worth.” (And yes, I am quoting directly there!).

**So with the numerous "what ifs" that exist, how do we know we are covered in our disaster plan? Are there steps that you consider universal regardless of the type of disaster?**

A: Yes, Begin by considering major disasters that can occur without warning. For instance, fire, flood, earthquake, vehicle smashing through your building, etc. Look towards the history of your geographic area to see what disasters may have happened in the past (if it happened once, it can happen again). Get input from your staff. What are their thoughts/ideas on disaster preparedness? Finally be sure to make use of the free resources available to you, such as SAMHSA’s Disaster Technical Assistance Center (DTAC): <https://www.samhsa.gov/dtac/about>

**What suggestion do you have for my Peers that are struggling with gambling addictions?**

A: In addition to being involved in a comprehensive recovery program, I encourage all of my clients with gambling disorder to participate in the self-exclusion program in their state. I think that the gambling commission in almost every state (if not every state) has a provision for someone to add their name to a “self-exclusion” list. Individuals in recovery can fill out a form and submit it (as a result, they will not be allowed to gamble for the duration of the exclusion). These forms typically have to be signed by the individual and notarized, which can be a challenge in the current COVID-19 pandemic, (but appointments can be made with notaries in most areas). Check with your state gaming authority to find out if the self-exclusions also apply to online gambling in the state. Here is an example of New York’s program: [https://www.gaming.ny.gov/gaming/Self\\_exclusion.php](https://www.gaming.ny.gov/gaming/Self_exclusion.php)

**In regards to programs that do use abstinence only, how do you suggest using telehealth or trying to change our approach during disasters, especially during the pandemic we are in now?**

A: While abstinence is an ideal situation, not all clients will achieve it. Unfortunately, I have also seen some programs that have a “three strikes and you are out” policy that discharges clients who experience multiple relapses. If this describes your program, I would consider “relaxing” this policy during these times, as increased stress associated with social isolation can have a negative impact on the individual in recovery. Additionally, discharging somebody from a program because they have experienced a lapse in their sobriety could result in feelings of rejection, worsening of social isolation, and could have other detrimental negative mental health effects.

Depending on your programs approach, continue to make contact with you client as frequently as possible, and review with them the abstinence goals they have established for themselves. Encourage them to consider such programs as Recovery Path, or if they lack access to a smart phone or computer, encourage them to journal and review with you during your Telehealth sessions. Online support group meetings could also be of tremendous help during these times.

**What do you recommend to professionals as we think about the long term effects of the current crisis and the need for behavioral health care over the next 12-18 months?**

A: I recommend that if your organization/practice did not have a disaster plan, you develop one. Additionally, if your organization/practice did not incorporate the disaster plan into the recovery plan, you do that as well.

**A long-term client of mine, who was on MAT, relapsed in their first week of quarantine. With fears of exposure to COVID-19, they are fearful of inpatient treatment. What are your recommendations for therapists working with clients who have relapsed during this time of quarantine & teletherapy?**

A: I would need to know more-by relapse, all referring to a one time “slip” are we talking two or three weeks of intense opioid use? I have already had several clients who have had a one or two time “slip” that did not require inpatient treatment. I would reach out to the prescriber, and discuss options for this client.

**Have you seen clients that have developed new effective coping skills in response to physical distancing? If so, are you noticing a trend?**

A: I have had some individual clients who have reported some advantages to their being at home. The theme I have seen emerging among them is one of engagement in self-care practices.

### What are the best support group discussion topics for staff of peer specialists?

A: It depends on the purpose of the group. During this time while things are being done at a distance, I would recommend groups that encourage everyone to have an opportunity to express how they are feeling. Allow the group adequate opportunities to share emotions, fears, anxieties, and concerns.

### Who is the Dr. Steve Dol? Who does webinars on worries and warriors?

A: Dr. Stephen Stahl. He is associated with the Neuroscience Education Institute in Carlsbad, California. You can learn more about him here: <http://www.neiglobal.com/General/StahlSM/tabid/117/Default.aspx>

Unfortunately, the video I was referring to is available only to subscribers. I was however able to find this video which described it as well: <https://www.mthfrdoctors.com/the-comt-gene/>

### What is meant by "Public Actions"? Riots?

A: Yes, that could be one example, another example of a public action contributing to a disaster are those who fail to believe that there is a pandemic occurring and continue to practice unsafe behaviors linked with the likelihood of causing/worsening the situation (for instance, failing to participate in social distancing by congregating, for instance).

### Does resilience and the ability to 'make meaning' from a disaster impact a person more or less that supports in a person's life during a disaster? What do you see as powerful factors of resilience?

A: I think it's individualized. There are many factors associated with resilience including a person's support system. We know that social support and attachments to others can have a profound impact on how people respond emotionally/psychologically to a disaster situation. Does the person view the disaster as a situation that they can master, or the end of the world? How adaptable are they to change? What about their own measures of self-efficacy? Do they tend to be optimists or pessimists? These are just some of the factors that impact a person's resilience.

## Recovery Path

Presenters: Jenna Tregarthen, CEO, MA and Elissa Chakoff, M.Ed., Ed.S., LMFT

### Are there fees associated with the recovery Path app. if so what are they?

A: Thank you for this question. There is no fee associated with the app when used by clients, and there is also no advertising in any of the applications. The Recovery Path Clinician app can be used with one client free of charge, and then you may select from plan options starting at \$8.99 per month, if you would like to expand access to more of your caseload. We also have group clinic account options, and are happy to provide more information regarding these. Please contact [support@recoverypath.com](mailto:support@recoverypath.com). Please note that all Recovery Path applications are compliant with HIPAA and the HITECH Act.

### What if peer does not have an iPhone?

A: Thank you for this access question. The Recovery Path app is available on both iPhone and Android. Approximately 81% of the population owns one of these devices, however we understand that there are still peers who will not. For this reason, our development team is working on a web application which we hope will be available in the next few months. Please check [www.recoverypath.com](http://www.recoverypath.com) for updates. If clients do not have access to a data plan, they may still utilize the application in offline mode, and their data will sync when they are next connected to Wi-Fi.

### Is it HIPAA compliant?

A: Good question. Yes, the application is compliant with HIPAA, the HITECH Act and GDPR and meets all privacy and security requirements detailed in these policies.

**Most of my clients are not able to download apps on phones that they pay monthly for by cards. Sounds like providers can access by website, but do clients like these have that capability?**

A: Thank you for this access question. If clients have either an Android or iPhone device, they may download the application (when connected to Wi-Fi if they have no data plan). If clients do not have data plans, the app has built-in offline mode so they will still be able to access some features and complete check-ins, which will sync the next time they are connected to Wi-Fi. You are correct, there is a web/desktop and iPhone and Android version for clinicians. Clients may resist linking at first (good opportunity for therapeutic discussion!), but we do see a higher level of app uptake and engagement by clients on our apps when they are linked with their treatment provider for accountability. It is important to continue to reward and praise clients for their work using the app and engaging in the work of recovery, and to use the data that they provide meaningfully in treatment.

**I just signed up and downloaded the app, however I am a clinician and would like to use this with my clients. What should I do? How do I do this?**

A: Fantastic, we hope that you enjoy exploring the tool and trying it out with your clients. To get started, just go to the app store on your phone and search for "Recovery Path Clinician". Install this application and create an account. Then, you are ready to go! The app has two example clients set up for you to explore. When you have a client who you think is a good fit, ask them to install the Recovery Path patient application and provide them with your Link Code. They just need to type this into the "Clinician Connect" section of their app, and once you accept their invitation, you will be linked! You can find your unique Link Code in the "Manage Clients" section of your account. We hope you find the tool to be valuable! Please don't hesitate to reach out with questions [support@recoverypath.com](mailto:support@recoverypath.com)

**So they must have some access to technology in some form to engage for all of these techniques ultimately? I have homeless clients with zero access to technology now that libraries are all closed.**

A: Sadly, this technology is only available to clients who either own an Android or iPhone at the moment and we are working on a web login. We recognize there is a broader problem of access to these tools for homeless populations, which we unfortunately do not have a good solution for right now.